STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 91

07943

1 PLACE OF DEATH

County Cecil

Village or City Chesapeake City (No. ..... St.; ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Wesley Atwell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

6 DATE OF BIRTH: January 17, 1857 (Month) (Day) (Year)

7 AGE: 89 yrs. 6 mos. 22 ds. If LESS than 1 day ..... hrs. or ..... min. ?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed or (employer):

9 BIRTHPLACE (State or country): Delaware

PARENTS

10 NAME OF FATHER: Edward Atwell

11 BIRTHPLACE OF FATHER (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Sallie Roberts

13 BIRTHPLACE OF MOTHER (State or country): Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Fred Lynn.
(Address) Chesapeake City Md.

15 Filed Aug 10 1946 Mrs. Ralph Rees Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug 8, 1946 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 1, 1946, to Aug 8, 1946, that I last saw him alive on Aug 5, 1946, and that death occurred on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH * was as follows:

Chronic Myocarditis.

C Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

Contributory Secondary: Senile, Gangrene Right foot.

(Duration) yrs. 2 mos. ds.

(Signed) Edward M Vaughan M. D.

192.. (Address) Middletown Dela.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .... yrs. .... mos. .... da. In the State, ... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL: Townsend Del DATE OF BURIAL: Aug 11, 1946

20 UNDERTAKER: C. Gustav Davis ADDRESS: Townsend Del

If more blanks are needed, address State Registrar. 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-0)

CERTIFICATE OF DEATH

★ 07944

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:

Union Hospital of Cecil County

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Earleville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Emma See Bailey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles H. Bailey (deceased) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 14, 1868

8. AGE:

Years	Months	Days	If less than one day
78	-	15	..... hrs. ..... min.

9. Birthplace: Cecil Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Edward See

13. Birthplace: Cecil County, Md.

MOTHER

14. Maiden name: Augusta - unknown

15. Birthplace: Cecil County, Md.

16. Informant: Susie E. Price (daughter)

Address: Earleville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 1 1946 (month) (day) (year)

Cemetery or crematory: Johnstown Cemetery

Location: Near Earleville Md.

18. Funeral director: Edward Fellows

Address: Millington Md.

19. Aug 31 1946 (Date rec'd by registrar) F H Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 1946, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/15 1946, to 8/29 1946

and that I last saw h[illegible] alive on aug 29 1946

Immediate cause of death: Bronchopneumonia — DURATION: 5 days

Due to: Fracture right hip (closed) femur — DURATION: Aug 14

Due to: Accidental fall. Given R.J. — DURATION:

Other conditions — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of August 29th, 1946

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury: Accidental fall Injured at work?

23. SIGNATURE: H. V. Davis M.D. M. D. or other

Address: Chesapeake City Md. Date signed 8/30/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07945

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perryville, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Perryville Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Helen Madeline Baker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

8.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1919

8. AGE: Years	Months	Days	If less than one day
26	10	2	hrs. min.

9. Birthplace: Perryville, Cecil, Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Charles Baker

13. Birthplace: Cecil Co., Md

MOTHER — 14. Maiden name: Ellen Patterson

15. Birthplace: Perryville, Cecil Co. Md.

16. Informant: Ellen Baker

Address: Perryville, R.D., Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-27-46 (month) (day) (year)

Cemetery or crematory: Patterson Home Cemetery

Location: Perryville R.D., Maryland

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Aug. 27 1946 (Date rec'd by registrar) Irma E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1946, at 10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1940 to Aug 23 1946 and that I last saw h.. alive on Aug 23 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to (Hemorrhage Pulmonary)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: O. Lewis M.D. M. D. or other

Address: Havre de Grace Md Date signed 8/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for the change of age is shown on C 107 10/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

07946

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil

City or town Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? # 3 mos. 22 days

Hospital, Institution, or street address where death occurred:
Employee at Hospital, Veterans Administration
Perry Point, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME John P. Bell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Henrietta Sophie Benner

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) December 21, 1893

8. AGE: Years	Months	Days	If less than one day
52 ~~53~~	4	1	___ hrs. ___ min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Employee Veterans Hospital

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Hospital Records

Address Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof August 11 1946 (month) (day) (year)

Cemetery or crematory Parkwood Cemetery

Location Taylor Ave., Baltimore, Md.

18. Funeral director Leonard J. Ruck Leonard J. Ruck

Address 5305 Harford Rd., Baltimore, Md.

19. Aug. 11 1946 (Date received by registrar) Irma E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1946 at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11 1946 to August 11 1946 and that I last saw him alive on

Immediate cause of death — DURATION

Cerebral Hemorrhage — Immediate

Due to

Due to

Other conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations --

Date of op.

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) -- (County) -- (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. L. Woodward M.D. Medical Examiner for Cecil County

Address Riverside Md. M. D. or other

Date signed 8-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

C7947

Reg. Dist. No. 95

1. PLACE OF DEATH

County Cecil Co.

City or town Near Conowingo Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Cecil Co.

City or town Near Conowingo Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Henry Boddy.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6.(b) Name of ~~husband~~ or wife Lulu Boddy

6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) July 5 1869

8. AGE: Years 77 | Months 1 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Conowingo Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Gideon J. Boddy

13. Birthplace Conowingo Md.

MOTHER 14. Maiden name Mary Jane Bell

15. Birthplace Conowingo Md.

16. Informant Lulu Boddy

Address Conowingo Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 10 1946
(month) (day) (year)

Cemetery or crematory Mt. Zion

Location Conowingo

16. Funeral director J. E. Tyson

Address Rising Sun Md.

19. Aug 9 1946 (Date received by registrar) Registrar

Permit issued 9-9-46

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7 1946 at 7.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-23 1946 to 8-7 1946 and that I last saw h.. alive on 8-6 1946

Immediate cause of death	DURATION
Cerebral Vascular accident	
Due to Thrombosis -	
Due to Chronic Myocarditis and Bronchitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Richardson M.D.
M. D. or other

Address R.D. Rising Sun Md. Date signed 8-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

07948 ★ Reg. Dist. No. 91

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Bucks

City or town: Fairless Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yr 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Pa. County: Delaware.

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. 622 Turner Ave. Drexel Hill

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Stephen Linn Boyer.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) April 8 1944

8. AGE: Years	Months	Days	If less than one day
2.	4	17.	hrs. min.

9. Birthplace: Philadelphia Pa. (Town, county, and state)

10. Usual occupation: Child.

11. Industry or business:

FATHER — 12. Name: Harry L. Boyer.

FATHER — 13. Birthplace: Drexel Hill Pa.

MOTHER — 14. Maiden name: Lillian Hamilton

MOTHER — 15. Birthplace: Philadelphia Pa

16. Informant: Harry L. Boyer.

Address: 622 Turner Ave Drexel Hill Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 29/46 (month) (day) (year)

Cemetery or crematory: Arlington Del Co

Location: Drexel Hill, Pa

18. Funeral director: H.W. Pippin

Address: Elkton, Md

19. Aug 26 1946 (Date rec'd by registrar) Mrs. Ralph H. Reed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25 1946 at 12:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Drowned.	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 8-25-46

Where did injury occur? Fairless Park (City or town) Bucks (County) Pa. (State)

Injured at home, farm, industry, public place (where?) Beach.

Means of injury: Fell in Elk River Injured at work? no

23. SIGNATURE: L.L. Dodson M.D. Medical Examiner.

Address: Chester Pa. M. D. or other

Date signed: 8-26-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

CERTIFICATE OF DEATH

Reg. Diat. No. 07942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Del. County: New Castle
City or town: Elsmere Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Henry A. Braune.

3.(b) Social Security Number: 222-09-5131

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married.

6.(b) Name of husband or wife: Maggie I Braune
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): June 12. 1877.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69	1	21		

9. Birthplace: Saxton Germany. (Town, county, and state)
10. Usual occupation: Farmer.
11. Industry or business:

FATHER
12. Name: Frederick Braune
13. Birthplace: Germany.

MOTHER
14. Maiden name: Frederika Jeckum
15. Birthplace: Germany.

16. Informant: Mary E Dexter
Address: 126 Ogle Ave. Wilmington Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 7 1946 (month) (day) (year)
Cemetery or crematory: Newark M E Cemetery
Location: Newark Delaware
18. Funeral director: J A Peppin
Address: Elkton Md

19. Aug 6 1946 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2. 1946, at 10.10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Compound Fracture of Skull. Fract. Meta.	
Due to: Fracture to Thorax & Lacerated Chest.	
Due to: Laceration & Bruise	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8-2-46
Where did injury occur? Elkton (City or town) Cecil (County) Md (State)
Injured at home, farm, industry, public place (where?) Road 40
Means of injury: Auto Bus. Injured at work? No

23. SIGNATURE: R L McDodson MD Medical Examiner Cecil County
M. D. or other
Address: Newark Del. Date signed: 8-2-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

07950

Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point, Md. Veterans Administration Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital, Perry Point,
How long in hospital or institution? Same as above Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: —
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 214 — 5th St., S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME: CARN, Frank Mahar

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): December 14, 1874

8. AGE: Years	Months	Days	If less than one day
71	8	17	— hrs. — min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: —

FATHER
12. Name: John M. Carn
13. Birthplace: Ireland

MOTHER
14. Maiden name: Elizabeth Taylor
15. Birthplace: Ireland

16. Informant: Hospital Records
Address: Veterans Administration Hospital Perry Point, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Sept. 5 1946 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace, Md.

18. Funeral director: Pennington & Son
Address: Pennington & Son, Havre de Grace, Md.

19. Sept. 4 1946 Irene E. Daughaday (Registrar)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 1946, at 5:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 13 1946, to August 31 1946, and that I last saw him alive on August 31 1946.

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 da.
Due to: Cerebral Arteriosclerosis	Unknown
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	Over 6 Mo.

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.: —
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: A.E. Trollinger
A.E. TROLLINGER, M.D., Clinical Director
Address: Veterans Administration Perry Point, Md. Date signed: 9-3-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

★ 07951 Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 113 W. Main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Esther Elizabeth Cebula

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Emil Cebula
6.(c) If alive, give age: 46 years
7. Birth date of deceased (mo., day, yr.): June 4, 1903

8. AGE: Years	Months	Days	If less than one day
43	2	11	...hrs. ...min.

9. Birthplace: Elkton, Md (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business
FATHER — 12. Name: Frank Vandergrift
13. Birthplace: Penn.
MOTHER — 14. Maiden name: Fannie Leubenmon
15. Birthplace: Elkton, Md
16. Informant: Emil Cebula
Address: Elkton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 15 /46 (month) (day) (year)
Cemetery or crematory: Elkton
Location: Elkton, Md
18. Funeral director: H. W. Pippin
Address: Elkton, Md
19. Aug 15 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 1946, at 5 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 1946, to Aug 13 1946
and that I last saw him alive on Aug 13 1946

Immediate cause of death	DURATION
Chronic Endocarditis	
Due to	
Due to	
Other conditions: Chronic Interstitial Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ...Injured at work?

23. SIGNATURE: J. Herbert Bates M.D. (M. D. or other)
Address: Elkton Md ...Date signed: 8/13/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (154)

CERTIFICATE OF DEATH

07952

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hours.
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 24 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: North East Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Baby Carlson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single.

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8-26-46.

8. AGE: Years — Months — Days — If less than one day: 6 hrs. ..... min.

9. Birthplace: Elkton Md.
(Town, county, and state)

10. Usual occupation: child

11. Industry or business

FATHER — 12. Name: Ernest Carlson.
13. Birthplace: Leona Md.

MOTHER — 14. Maiden name: Margaret Thompson
15. Birthplace: Wytheville Va.

16. Informant: Ernest Carlson.
Address: North East Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 28 1946 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Rising Sun Rural Md
18. Funeral director: Joseph R Frazer
Address: North East Md

19. Aug 28 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/27 1946 at 3300 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/26 1946, to 8/27 1946
and that I last saw h.. alive on 8/27 1946

Immediate cause of death	DURATION
Premature	
5 mo Gestation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. L. Dodson MD
M. D. or other
Address: Rising Sun Md. Date signed 8/27/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

07953 Reg. Dist. No. 9-2

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Cathedral St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cathedral -
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Rev. Creswell, George A.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 22, 1896

8. AGE: Years	Months	Days	If less than one day
50	7	4	hrs. min.

9. Birthplace: Wilmington, Del (Town, county, and state)
10. Usual occupation: Catholic Church. O.S.F.S.
11. Industry or business
FATHER 12. Name: George Creswell
FATHER 13. Birthplace: Wilmington, Del.
MOTHER 14. Maiden name: Mary Rafferty
MOTHER 15. Birthplace: Wilmington, Del
16. Informant: Father Keller
Address: Elkton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 30, 46 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Wilmington, Del
18. Funeral director: H. W. Lippincott
Address: Elkton, Md
19. Aug 29 1946 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION E.D.T.

20. DATE OF DEATH: August 26 1946 at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1945 to Aug. 26 1946 and that I last saw him alive on Aug. 26 1946

Immediate cause of death	DURATION
Carcinoma of Stomach	Dec. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of Stomach
Date of op.: Jan. 1946
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Mitford W. Lippincott M.D.
M. D. or other
Address: Elkton, Md. Date signed: Aug. 26, '46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

07954

★ Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Omar D Brothers Jr. | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Reba Miller Brothers
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Nov 17 1880

8. AGE: Years	Months	Days	If less than one day
65	7	17	..... hrs. ..... min.

9. Birthplace: Leonardtown Md
(Town, county, and state)
10. Usual occupation: Lawyer.
11. Industry or business

FATHER
12. Name: Alpheus Brothers
13. Birthplace: Cecil Co Md.

MOTHER
14. Maiden name: Jane Price
15. Birthplace: Leonardtown Md.

16. Informant: Omar D Brothers Jr.
Address: Elkton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 6 1946 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Colora Cecil Co. Maryland
18. Funeral director: H. W. Lippincott
Address: Elkton. Maryland
19. Aug 6 1946 (Date rec'd by registrar) F B Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3 1946, at 2.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Bell Doctor MD Medical Examiner Cecil County
Address: Elkton Md. M. D. or other
Date signed: 8/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125-B)

CERTIFICATE OF DEATH

07955

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs. 8 mos. 19 da.

Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 17 yrs. 8 mos. 19 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County: Elk

City or town: St. Mary's,
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 462 Chestnut St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: DORNISH, Edward

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 1, 1894

8. AGE:

Years	Months	Days	If less than one day
51	8	10	____ hrs. ____ min.

9. Birthplace: St. Mary's, Pa.
(Town, county, and state)

10. Usual occupation: Moulder

11. Industry or business: Glass factory

FATHER
12. Name: John Dornish
13. Birthplace: Forest, Pa.

MOTHER
14. Maiden name: Mary Swanchfisher
15. Birthplace: Emporium, Pa.

16. Informant: Records, Vets. Adm. Hospital
Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof August 12, 1946 (month) (day) (year)

Cemetery or crematory: St. Mary's Catholic Cemetery

Location: St. Marys, Elk Co., Pa.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Aug. 12 1946 (Date rec'd by registrar) Irma E. Dawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11 1946 at 8:19 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23 1928, to August 11 1946 and that I last saw him alive on August 11 1946

Immediate cause of death	DURATION
HEPATITIS, ACUTE, CAUSE UNKNOWN	2 weeks
Due to:	
Due to:	
Other conditions: Dementia Praecox, Hebephrenic type	17 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ——

Date of op. ——

Autopsy results: ——

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of ——

Where did injury occur? —— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury —— Injured at work? ——

23. SIGNATURE: A. E. Trollinger, M.D., Clinical Director

Address: VAH, Perry Point, Md. Date signed: 8-12-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07956

Reg. Diat. No. 95

1. PLACE OF DEATH:
County: Cecil
City or town: Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Willis Seldom Ely.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ada Ely
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Sept. 28. 1883

8. AGE: Years	Months	Days	If less than one day
62	10	27	hrs. min.

9. Birthplace: Bucks Co. Penna. (Town, county, and state)
10. Usual occupation: Real Estate + Insurance Agent
11. Industry or business

FATHER
12. Name: Mark Ely
13. Birthplace: Pa.

MOTHER
14. Maiden name: Mary Seldom
15. Birthplace: Md.

16. Informant: Mrs. Ada Ely
Address: Rising Sun Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 27 1946 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Colora, Md.
18. Funeral director: J. E. Tyson
Address: Rising Sun Md.

19. Aug 26 1946 (Date rec'd by registrar) E. M. Worthington Registrar
Permit issued Aug 26-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 23 1946 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiac	
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner Cecil County
M. D. or other
Address: Rising Sun Md. Date signed: 8-26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115C)

CERTIFICATE OF DEATH

07957 Reg. Diat. No. 91

1. PLACE OF DEATH:
County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 78 years.
Hospital, institution, or street address where death occurred:
Chesapeake City
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas M. Fillingame

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Wh	Married

6.(b) Name of husband or wife: Lillie Mae Fillingame
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): March 26, 1868

8. AGE: Years	Months	Days	If less than one day
78	5	29	...hrs. ...min.

9. Birthplace: Bohemia Manor, Cecil Co.
(Town, county, and state)
10. Usual occupation: Retd Farmer
11. Industry or business:
FATHER 12. Name: John W. Fillingame
13. Birthplace: Maryland
MOTHER 14. Maiden name: Christiana Amonett
15. Birthplace: Maryland
16. Informant: Mrs Lillie Mae Fillingame
Address: Chesapeake City, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 29/46 (month) (day) (year)
Cemetery or crematory: Bethel
Location: Near Chesapeake City, Md
18. Funeral director: H. W. Pippin
Address: Elkton, Md
19. August 29th 1946 (Date rec'd by registrar) Mrs Rudolph D. Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1946, at 1:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945 to Aug 27 1946
and that I last saw h... alive on Aug 25 1946

Immediate cause of death	DURATION
Acute Myocardial failure	1 hour
Due to: Arteriosclerosis & Chronic Nephritis	1½ years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. V. Downs M.D.
M. D. or other
Address: Chesapeake City Md Date signed: 8/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of name [illegible]

STATE OF MARYLAND—CERTIFICATE OF DEATH

FILE No. 1946 AUG 20 07958

1. PLACE OF DEATH (835a)

County Kent Registration Dist. No. 90

Village or City Warwick Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Elva Mary Garner If U. S. Veteran, specify WAR

(a) Residence: No. Warwick St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female | 4. COLOR OR RACE white | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Garner

6. DATE OF BIRTH (month, day, and year) Nov. 15 1868

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
77	8	29	

OCCUPATION

8. Trada, profassion, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Own home

10. Data deceased last workad at this occupation (month end year) 1946

11. Total tima (yaars) spant in this occupation

12. BIRTHPLACE (city or town) Maryland (Stata or country)

FATHER

13. NAME Alfred Jones

14. BIRTHPLACE (city or town) Maryland (Stata or country)

MOTHER

15. MAIDEN NAME Josephine Peddler

16. BIRTHPLACE (city or town) Maryland (State or country)

17. INFORMANT Josephine Padley (Address) Middletown Del.

18. BURIAL, CREMATION, OR REMOVAL Place Warwick Md. Date Aug 18, 1946

19. UNDERTAKER Lester Daniels (Address) Townsend Del

20. FILED Aug 17th, 1946 Irma G. Burke Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug 14th, 1946 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended decaasad from Aug 12, 1946, to Aug 14, 1946

I last saw h[illegible] alive on Aug 14, 1946, death is said to have occurred on tha date statad above, at 10:20 P.m.

The PRINCIPAL CAUSE OF DEATH and ralatad causes of importance were as follows:

	Date of onset
(a) Apoplexy	8/10/46
Other ~~Contributory Causes~~ of importance: Arterio sclerosis	1940

Name of operation Date of

What test confirmed diagnosis? Was thare an autopsy?

23. If daath was dua to external causes (VIOLENCE) fill in also the following:

Accident, suicida, or homicida? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was diseasa or injury in any way ralated to occupation of deceasad? no

If so, specify

(Signed) J. R. Mills M. D.

(Address) Middletown Del

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07959

Reg. Diat. No. 95

1. PLACE OF DEATH:

County: Cecil

City or town: Rising Sun. Rural.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Rising Sun Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Jackson Garris

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Ovria Garris

6.(c) If alive, give age: 43 years

7. Birthdate of deceased (mo., day, yr.): Jan. 5. 1898

8. AGE:

Years	Months	Days	If less than one day
48	7	26	...hrs. ...min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Oliver Garris

13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Betty Black

15. Birthplace: North Carolina

16. Informant: Mrs. Ovria Garris

Address: Rising Sun Md R. F. D.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept 3 1946 (month) (day) (year)

Cemetery or crematory: Bowlsmere

Location: Rising Sun md

18. Funeral director: J. E. Tyson

Address: Rising Sun. Md.

19. Filed Sept 3 1946 L. M. Worthington Registrar

Permit issued Sep 3-1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 1946 at 1:30 - 4:05 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19 43, to 8/31 19 46

and that I last saw h... alive on March 19 46

Immediate cause of death	DURATION
Pulmonary edema	
Due to: Prostatic carcinoma	2yrs+
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank H Ridgely M. D.

M. D. or other

Address: 48 N 4th — Oxford Pa Date signed: Sept 3 1946

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07960

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs. 3 mos. 15 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 14 yrs. 3 mos. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3. (a) FULL NAME: GIZA, Frank

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Gertrude Giza

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 22, 1896

8. AGE: Years	Months	Days	If less than one day
50	6	20	..... hrs. ..... min.

9. Birthplace: New York State
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Unknown
13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown
15. Birthplace: Poland

16. Informant: Records, Vets. Adm. Hospital,
Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: August 20, 1946 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Aug 20, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 1946 at 8:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1932, to August 15, 1946 and that I last saw him alive on August 15, 1946

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic, far advanced, active	18 mos.
Due to	
Due to	
Other conditions: Dementia Praecox, Hebephrenic type	14 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE: R. E. TROLLINGER, M.D., Acting Medical Dir.

Address: VAH, Perry Point, Md. Date signed: 8-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

07961

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mo
Hospital, institution, or street address where death occurred: 56 Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
Street No. 56 Main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lucy Virginia Harlan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife: Henry C. Harlan — 6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 19 ~~1848~~ 56

8. AGE: Years 89 | Months 11 | Days 15 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Retired House Keeper

11. Industry or business

FATHER — 12. Name: Amos H. Hughes
13. Birthplace: Md.

MOTHER — 14. Maiden name: Hannah Adams
15. Birthplace: Md.

16. Informant: Amos H. Harlan
Address: 56 Main St. Port Deposit Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 6 1946 (month) (day) (year)
Cemetery or crematory: Wesleyan Chapel
Location: Harford Co. Md.

18. Funeral director: H. Madison Mitchell
Address: Havre de Grace Md.

19. Aug. 5 1946 (Date received by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 4 1946, at 3 50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1946 to Aug 4 1946 and that I last saw h[er] alive on Aug 3 1946

Immediate cause of death	DURATION
Cerebral Haemorrhage	2 da.
Due to: Generalized atherosmatosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other
Address: Perryville Md. Date signed: Aug 5 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07962

Reg. Diat. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: 196 Hollingsworth Manor Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Del. County: Sussex
City or town: Georgetown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 N. Front St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Dora Bell Harbans

3.(b) Social Security Number 222-01-1361

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	married

6.(b) Name of husband or wife: Thomas P Harbans
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): July 16 1884

8. AGE: Years: 62. Months: 1 Days: 9 If less than one day: hrs. min.

9. Birthplace: Pulaski Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Ray. Martin
13. Birthplace: Virginia Va.

MOTHER
14. Maiden name: Elizabeth Martin
15. Birthplace: Va.

16. Informant: Ina Ruley Jackson
Address: 196 Hollingsworth Manor Elkton Md.

17. Burial (Burial, cremation, or removal—which?) Date thereof: Aug 29, 1946 (month) (day) (year)
Cemetery or crematory: The Union Cemetery
Location: Georgetown Del.

18. Funeral director: W. Tapperi
Address: Elkton, Md.

19. Aug 26 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 26 1946, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Coronary	
Coronary Occlusion	
Due to: Heart Failure	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner Cecil County
M. D. or other
Address: Elkton Md. Date signed: 8-26-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07963

CERTIFICATE OF DEATH

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration Hospital, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yr. 2 mo. 21 da.

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Texas County: Ellis

City or town: Ennis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 905 Clay Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: HOPKINS, Leslie LeRoy

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
Approx. 48			...hrs. ...min.

9. Birthplace: Ennis, Texas
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: –

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration Hosp. Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 4 1946 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Sept. 4 1946 (Date rec'd by registrar) Irma E. Daughton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-29-46 19..., at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1938 to August 29 1946 and that I last saw him alive on August 29 1946

Immediate cause of death	DURATION
Syphilis of the Central Nervous System, Meningo Encephalitic type	Unknown
Due to	Over 8 years
Due to	
Other conditions: Psychosis with Syphilis of the Central Nervous System, Meningo-Encephalitic Type. (Include pregnancy within 3 months of death)	Unknown
Major findings of operation:	Over 8 years

Date of op.

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: 0 Date of: –

Where did injury occur? – (City or town) – (County) – (State)

Injured at home, farm, industry, public place (where?): –

Means of injury: – Injured at work? –

23. SIGNATURE: J. E. Mollinger, M.D., Clinical Director

Address: Veterans Administration Hospital, Perry Point, Md. Date signed: 9-3-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

07964

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Cecil
City or town: Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? less than one (1) day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? less than one (1) day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: U.S.N.T.C., Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Quarters "BB"
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ellen Mack

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1 August 1946

8. AGE: Years | Months | Days | If less than one day: 11 hrs. 10 min.

9. Birthplace: Bainbridge, Cecil County, Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: William Paden Mack
13. Birthplace: Hillsboro, Ill.

MOTHER
14. Maiden name: Ruth George Mack
15. Birthplace: Mare Island, Calif.

16. Informant: William P. Mack
Address: Quarters "BB" U.S.N.T.C., Bainbridge, Md.

17. Cremation (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Hospital
Location: Bainbridge, Md.
18. Funeral director:
Address:

19. Aug 7 1946 Irma E. Dougherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 August 1946 at 9:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1, 1946 to August 1, 1946 and that I last saw her alive on August 1, 1946

Immediate cause of death	DURATION
Asphyxia	
Due to: Atelectasis, Rt. lung	
Due to: Enlarged thymus	
Due to - Prematurity	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Graham R. Johnston
GRAHAM R. JOHNSTON, Comdr. (MC) USN
M. D. or other
Address: Out-Patients Dept. U.S.N.T.C. Bainbridge, Md. Date signed: 2 Aug. 1946

RKG

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

67965

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs. 1 mo. 28 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 9 yrs. 1 mo. 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Arkansas County: Benton

City or town: Rogers
(If outside city or town limits, write RURAL and give nearest town)

Street No.: None
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: MC CLANAHAN, Samuel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): August 26, 1896

8. AGE: Years	Months	Days	If less than one day
49	11	19	____ hrs. ____ min.

9. Birthplace: Texas
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER
12. Name: Edward McClanahan
13. Birthplace: Texas

MOTHER
14. Maiden name: Annie - McClanahan
15. Birthplace: Texas

16. Informant: Records, Vets.Adm. Hosp.

Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: August 16, 1946 (month) (day) (year)

Cemetery or crematory: National Cemetery

Location: Fayetteville, Arkansas

18. Funeral director: Pennington & Son
PENNINGTON & SON

Address: Havre de Grace, Md.

19. Aug. 16 19 46 (Date received by registrar) Irma E. Bamford Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 19 46, at 8:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 19 37, to August 14 19 46 and that I last saw him alive on August 14 19 46

	DURATION
Immediate cause of death: Peritonitis	over 24hrs
Due to: Intestinal Obstruction	12 hrs.
Due to: Malignancy of the Colon	Unknown
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: As above

Date of op. 8-14-46

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: --

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, M.D., ACTING MANAGER

Address: VAH, Perry Point, Md. Date signed: 8-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

07966 42

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Cecil

City or town Elkton Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Cecil

City or town Elkton Rural (Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. RD 5
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR nor a veteran

3. (a) FULL NAME Edward Moore

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma Louise Moore

6(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Dec 7 1861

8. AGE:

Years	Months	Days	If less than one day
84	8	18	hrs. min.

9. Birthplace Cherry Hill Cecil Co Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name William Moore
13. Birthplace Del

MOTHER
14. Maiden name Jane Stewart
15. Birthplace Del

16. Informant Mrs Edward Moore

Address Elkton RD 5 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 28 1946 (month) (day) (year)

Cemetery or crematory Methodist

Location Cherry Hill Md

18. Funeral director Joseph A Grant

Address North East Md

19. Aug 27 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1946, at 9:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4th 1946, to August 25 1946

and that I last saw him alive on August 25 1946

Immediate cause of death	DURATION
Prostatic Hypertrophy	1 year
Due to	
Due to	
Other conditions Coronary sclerosis	4 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Wallace M Johnson MD
M. D. or other

Address Newark Del. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

07967

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration Hosp. Perry Point Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hosp. Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2310 - 20th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: PARKHILL, Leroy P.

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dolly Nesbit

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): March 10, 1894

8. AGE: Years	Months	Days	If less than one day
52	5	16	- hrs. - min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Food checker

11. Industry or business: -

FATHER
12. Name: Joseph Parkhill
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Emma Bute
15. Birthplace: Washington, D.C.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8-27-46 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Washington, D.C.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Aug. 27 1946 Irma E. Dunkle (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1946 at 3:50A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1946 to August 26 1946 and that I last saw him alive on August 26 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	18 hrs.
Due to: Arteriosclerosis, cerebral	Unknown
Other Conditions:	
Due to: Psychosis with cerebral arterio-sclerosis	3 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: - Date of op. -

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE: A.E. Trollinger
A.E. TROLLINGER, M.D. Clinical Director
Address: Veterans Administration, Perry Point, Md. Date signed 8-27-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-a)

07968

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:
County: Cecil
City or town: Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Born there
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard PoRomy Jr. **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 1 1946

8. AGE: Years 0 | Months 0 | Days 3 | If less than one day: hrs. min.

9. Birthplace: Rising Sun, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: Richard Poromy
13. Birthplace: New York State

MOTHER
14. Maiden name: Doris Rasay
15. Birthplace: Cecil Co Md

16. Informant: Doris Poromy
Address: Rising Sun, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 5 46 (month) (day) (year)
Cemetery or crematory: Little Britain, Lancaster Co Pa.
Location: Nottingham R.D. Pa.

18. Funeral director: F L Kauffman
Address: Peach Bottom Pa.

19. Aug 5 1946 L. M. Worthington per. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3 1946, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1946 to August 3 1946
and that I last saw h... alive on Aug 3 46 1946

	DURATION
Immediate cause of death: Intra Cranial Hemorrhage	
Due to: Breech birth, Premature weak infant	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: F B Robinson M.D.
M. D. or other
Address: Oxford, Pa. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 175

07969 P

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH
County: Cecil
City or town: Principio
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred: .....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3712 Hickory Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME Norman Clay Rhodes.

3.(b) Social Security Number 225-14-2854

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Catherine Rhodes
6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): Aug 22 1922.

8. AGE: Years: 24 | Months: | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Edray West Va
(Town, county, and state)

10. Usual occupation: Bus Driver

11. Industry or business: Balto. Motor Coach Co.

FATHER
12. Name: Hard Rhodes
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Mary Susan Cockran
15. Birthplace: West Virginia

16. Informant: Catherine Rhodes
Address: 3712 Hickory Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 29-46 (month) (day) (year)

Cemetery or crematory: Druid Ridge
Location: Pikesville Maryland

18. Funeral director: Ellsworth Ardmacost
Address: 3911 Liberty Heights Ave.

19. 8/27 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 25 19 46, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Compound Fracture of skull	
Due to: Fracture of neck	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8/25-46
Where did injury occur? Principio (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?): Route 40.
Means of injury: automobile Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md. Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

Reg. Dist. No. 7096

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Va. County: Leland.

City or town: Riner Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lena Ethel Roop.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife: Dalton Lee Roop.

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): May 1914.

8. AGE: Years	Months	Days	If less than one day
33	3		hrs. min.

9. Birthplace: Riner Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: D L Manson.

FATHER 13. Birthplace: Riner Va.

MOTHER 14. Maiden name: Leonie Booth.

MOTHER 15. Birthplace: Riner Va.

18. Informant: Dalton Lee Roop. Address: Pt Deposit Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 9 1946 (month) (day) (year)

Cemetery or crematory

Location: To Christiansburg Montgomery Co. Va

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Aug 9 1946 (Date received by registrar) Dennis E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 8 1946, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Drowned.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 8-8-46

Where did injury occur? Port Deposit Cecil Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Susquehanna River

Means of injury: Row Boat Sunk. Injured at work?

23. SIGNATURE: R L Dodson M.D. Medical Examiner for Cecil County
M. D. or other

Address: Rising Sun Md. Date signed 8-9-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (116)

07971

CERTIFICATE OF DEATH

Reg. Dist. No. 91

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 77 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Estella G Sager

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: John J Sager
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 27 1868

8. AGE:	Years	Months	Days	If less than one day
	77			hrs. min.

9. Birthplace: Chesapeake City Md
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business:
FATHER 12. Name: Jacob Truse
13. Birthplace: Chesapeake City Md
MOTHER 14. Maiden name: Mary J Hemphill
15. Birthplace: Chesapeake City Md
16. Informant: Mrs Lydia Sager Bendler
Address: Chesapeake City Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 12 46 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Chesapeake City R D
18. Funeral director: H W Thompson
Address: Elkton, Md
19. August 11th 1946 Mrs Ralph H Bell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 9 1946 at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945 to Aug 9 1946
and that I last saw her alive on Aug 8 1946

	DURATION
Immediate cause of death: Paralysis Infarction Coronary Thrombosis	4 days
Due to: Senile dementia	1 year.
Due to: Old age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos J Davis M.D. M. D. or other
Address: Chesapeake City Md. Date signed: 8/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

17972

Reg. Dist. No. 90

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Del. County: Newcastle
City or town: Wilmington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 16 Bedford Drive Edgemere Gardens
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Earl M. Stata

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Beatrice T. Stata — 6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 6 1909

8. AGE: Years	Months	Days	If less than one day
37	3	12	____ hrs. ____ min.

9. Birthplace: Bristol Pa.
(Town, county, and state)
10. Usual occupation: Asst. Manag. Del AAA
11. Industry or business:
FATHER 12. Name: Robert L. Stata
13. Birthplace: Virginia
MOTHER 14. Maiden name: Hardy
15. Birthplace: Virginia
16. Informant: Mrs. Beatrice T. Stata
Address: 16 Bedford Drive, Edgemere Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 23 1946 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Chesapeake City Md.
18. Funeral director: Edward F. Allbaugh
Address: Millington Md.
19. Aug 21 1946 (Date rec'd by registrar) Irma M. Burke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18 1946 at 1 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____ to ____ 19____ and that I last saw h____ alive on ____ 19____

Immediate cause of death	Drowned.	DURATION
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date at: 8/18-46
Where did injury occur? Grove Point (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Fell of boat Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Elkton Md. Date signed: 8/20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

07973

★ Reg. Dist. No. 9/

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

1. PLACE OF DEATH:
County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Chesapeake City Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eugene Snyder Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife: Rose Williams
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 10 1860

8. AGE: Years	Months	Days	If less than one day
85	8	30	hrs. min.

9. Birthplace (Town, county, and state)
10. Usual occupation: retired
11. Industry or business: Ellmwille N Y

FATHER
12. Name: no inf
13. Birthplace: No information

MOTHER
14. Maiden name: No information
15. Birthplace: No information

16. Informant: Arthur C Tollefson
Address: Chesapeake City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 12 1946 (month) (day) (year)
Cemetery or crematory: Mount Hope Cemetery
Location: Mount Hope N J

18. Funeral director: H A Pierson
Address: Elkton Md

19. August 11th 1946 (Date rec'd by registrar) Mrs Ralph D Reed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 1946, at 9:22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to Aug 9 1946 and that I last saw h... alive on Aug 9 1946

Immediate cause of death	DURATION
Acute Cardiac failure	3 hours
Due to: Chronic myocarditis	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] Davis M.D. M. D. or other
Address: Chesapeake City Md Date signed: 8/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

07974

CERTIFICATE OF DEATH

Reg. Diat. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration Hosp. Perry Point Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs 1 month 16 days
Hospital, institution, or street address where death occurred:
Veterans Administration Hosp. Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: —
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2426 Snow Court, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: WILLIAMS, Francis

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Bessie Williams
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
Approx. 72	—	—	— hrs. — min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: —

FATHER
12. Name: Sam Williams
13. Birthplace: Maryland

MOTHER
14. Maiden name: Cecil (Maiden name unknown)
15. Birthplace: Washington, D.C.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof August 7, 1946 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: J. H. Lowe
Address: 2426 Eye St., N.W., Washington, D.C.

19. Aug. 7 1946 (Date rec'd by registrar) Irene E. Doughty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1946 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21, 1944, to August 6, 1946 and that I last saw him alive on August 6, 1946

Immediate cause of death	DURATION
Penumonia, bronchial	10 days
Due to: Acute Pulmonary Oedema	4 days
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	Approx. 9 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: A.E. Trollinger A.E. TROLLINGER, M.D. Clinical Director Medical Officer
Address: Veterans Administration, Perry Point, Md. Date signed 8-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M